DWS-OSD 61NH
Rev. 07/2007

State of Utah
Department of Workforce Services
APPLICATION ADDENDUM FOR NURSING HOME CLIENTS

Date Received

PID#: _____

Name:	SS#:	Case#:
Name of Nursing Home:	Medicare#:	V.A. Contract Dates:
Address of Nursing Home:	Date Entered Nursing Home:	Medicare Covered Dates:

1. Do you plan to leave the nursing home within 6 months? ☐ Yes ☐ No

2. Were you in the hospital or other institution prior to entering this nursing home? ☐ Yes ☐ No

IF YES, FILL IN THE BOXES BELOW		
Name of Institution:	Date of Entry:	Date of Release:

3. Has your marital status changed since you entered the nursing home? ☐ Yes ☐ No
   Please explain: _____

4. Where did you live before entering the nursing home?

INDICATE ADDRESS AND WITH WHOM YOULIVED

5. Do you own a home or maintain a life estate interest in a home? ☐ Yes ☐ No

IF YES, FILL IN THE BOXES BELOW	
Who currently lives in the home?	Relationship to Them:

6. Do you intend to return to your home? ☐ Yes ☐ No

7. Have you sold or transferred a home or any other property, money, vehicle or other assets in the past 36 months?

IF YES, FILL IN THE BOXES BELOW	
Date of Sale or Transfer:	Amount of Money Received:

   Do you still get money from this sale? ☐ Yes ☐ No
   Please explain: _____

8. Do you have health insurance? ☐ Yes ☐ No
   Does this insurance include your spouse? ☐ Yes ☐ No

IF YES, FILL IN THE BOXES BELOW			
Name of Company/Policy #:	Premium:	Paid (circle one): Monthly Bi-Annual Quarterly Annually	Next Payment Due:
Who pays the premium?	$		

WE MUST HAVE PROOF OF THE VALUE OF ALL ASSETS TO DECIDE IF THE CLIENT IS ELIGIBLE FOR MEDICAID. BANK STATEMENTS, PASSBOOKS, AND LIFE INSURANCE POLICIES CAN PROVE THE VALUE OF SOME ASSETS.

9. Name of bank/credit union: _____ Name of second bank/credit union: _____
   Checking balance: _____ Checking balance: _____
   Savings Balance: _____ Savings balance: _____
   Contents of safety deposit box: _____
   Other financial institutions: _____

10. Name of life insurance company: _____
    Whole life or term? (circle one) Face value: $ _____ Case value: $ _____
    Name of second life insurance company: _____
    Contents of safety deposit box: Face value: $ _____ Case value: $ _____

D3530701359

11. Have you or your spouse owned or jointly owned any of these in the past 36 months:

ASSET	Y/N	VALUE	AMOUNT OWED	DATE SOLD OR TRANSFERRED
Case on hand	☐ Yes ☐ No	$	$	
IRA/Keogh Accounts	☐ Yes ☐ No	$	$	
Money Market Accounts	☐ Yes ☐ No	$	$	
Prepaid Burial Fund or Trust	☐ Yes ☐ No	$	$	
Burial, Insurance or Funeral Plan	☐ Yes ☐ No	$	$	
Stocks & Bonds	☐ Yes ☐ No	$	$	
Land, Mineral Rights	☐ Yes ☐ No	$	$	
Buildings	☐ Yes ☐ No	$	$	
Time Shares	☐ Yes ☐ No	$	$	
Cemetery Plot	☐ Yes ☐ No	$	$	
Water Stock	☐ Yes ☐ No	$	$	
Oil and Gas Leases	☐ Yes ☐ No	$	$	
Tools	☐ Yes ☐ No	$	$	
Live Stock	☐ Yes ☐ No	$	$	
Vehicles	☐ Yes ☐ No	$	$	
Recreational Vehicles	☐ Yes ☐ No	$	$	
Sales Contract	☐ Yes ☐ No	$	$	
Other (Specify)	☐ Yes ☐ No	$	$	

12. Are you, your spouse, your child, or your parent a Veteran? ……☐ Yes ☐ No

IF YES, FILL IN THE BOXES BELOW			
Name of Veteran #1:	Relationship to You:	Name of Veteran #2:	Relationship to You:
V.A. Claim #:	Service #:	V.A. Claim #:	Service #:

Did he serve in wartime?	☐ Yes ☐ No	Did he serve in wartime?	☐ Yes ☐ No
Does he or did he receive Veterans benefits?	☐ Yes ☐ No	Does he or did he receive Veterans benefits?	☐ Yes ☐ No
Does he have a service connected disability?	☐ Yes ☐ No	Does he have a service connected disability?	☐ Yes ☐ No
Date of death: _____		Date of death: _____	
Was his death service-connected?	☐ Yes ☐ No	Was his death service-connected?	☐ Yes ☐ No
Was he in the armed services when he died?	☐ Yes ☐ No	Was he in the armed services when he died?	☐ Yes ☐ No

13. Have you filed for any V.A. benefits? …..☐ Yes ☐ No If so, when? _____

_____ _____

Your Signature Date

14. IF YOU ARE A FRIEND OR RELEATIVE COMPLETING THIS FORM FOR SOMEONE IN A NURSING HOME, FILL IN THESE BOXES. BY COMPLETING THIS FORM, YOU ARE ATTESTING TO THE ACCURACY OF THE INFORMATION PROVIDED OT THIS OFFICE.

Your Name:	Relationship to Applicant:	Phone#:

The state has the right to recover from your (the client's) estate all money spent to pay your medical bills if you receive Medicaid at any time while you are 55 years of age or older and if: 1) you have no surviving spouse, 2) you have no surviving children under age 21, and 3) you have no surviving blind or disabled children.